

Appendix 8

Instructions for the Completion of the Prior Authorization Request Form (PA/RF)

ELEMENT 1 - PROCESSING TYPE

Enter the appropriate three-digit processing type from the list below. The “process type” is a three-digit code used to identify a category of service requested. Use 999 - “Other” only if the requested category of service is not found in the list. Prior Authorization and Spell of Illness requests will be returned without adjudication if no processing type is indicated.

- * 120 - Home Health/Private Duty Nursing Services/Home Health Therapy/Respiratory Care Services/Personal Care Services -- Use this code if the recipient receives other home health services from your agency in addition to personal care.
 - 121 - Personal Care Services -- Use this code if the recipient does not receive other home health services.
 - 130 - Durable Medical Equipment
 - 132 - Disposable Medical Supplies
 - 999 - Other (use only if the requested category of service is not listed above)
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- * Includes PT, OT, Speech, and may include personal care provided by dually certified home health agencies

ELEMENT 2 - RECIPIENT'S MEDICAID IDENTIFICATION NUMBER

Enter the *ten-digit* recipient identification number as found on the recipient's Wisconsin Medicaid identification (ID) card.

ELEMENT 3 - RECIPIENT'S NAME

Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's Medicaid ID card.

ELEMENT 4 - RECIPIENT'S ADDRESS

Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH

Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's Medicaid ID card.

ELEMENT 6 - RECIPIENT'S SEX

Enter an “X” to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS, AND ZIP CODE

Enter the name and complete address (street, city, state, and zip code) of the billing provider. No other information should be entered in this element since it also serves as a return mailing label.

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider. If the performing provider phone number is different than the phone number of the billing provider, please include both phone numbers.

ELEMENT 9 - BILLING PROVIDER'S MEDICAID PROVIDER NUMBER

Enter the eight-digit Medicaid provider number of the billing provider.

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS

Enter the appropriate *International Classification of Diseases, 9th Revision, Clinical Modification, Fourth Edition (ICD-9-CM)* diagnosis code and description most relevant to the recipient's current medical condition.

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ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS

Enter the appropriate *International Classification of Diseases, 9th Revision, Clinical Modification, Fourth Edition* (ICD-9-CM) diagnosis code and description additionally descriptive of the recipient's clinical condition.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS (not required)

ELEMENT 13 - FIRST DATE OF TREATMENT (not required)

ELEMENT 14 - PROCEDURE CODE(S)

Enter the appropriate Revenue or HCPCS procedure code for each service/procedure/item requested, in this element. When the procedure may be one of two at any given time, request both procedure codes (W9045/W9046, W9930/W9940). Personal care-only agencies use W9900 for personal care worker (PCW) services. Dually certified home health agencies use W9903 for PCW services.

ELEMENT 15 - MODIFIER (not required)

ELEMENT 16 - PLACE OF SERVICE

Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

<u>Code</u>	<u>Description</u>
0	Other
4	Home [all personal care and travel time services are provided in the home, use POS 4]

ELEMENT 17 - TYPE OF SERVICE

Enter the appropriate type of service code for each service/procedure/item requested.

<u>Numeric</u>	<u>Description</u>
1	Medical (including: Home Health, Independent Nurses, PT, OT, ST, Personal Care, Respiratory Care)
9	Other (use only for DMS)

ELEMENT 18 - DESCRIPTION OF SERVICE

Enter a written description corresponding to the appropriate Revenue, HCPCS, or National Drug Code (NDC) procedure code for each service/procedure/item requested.

When requesting home health services, indicate the number of visits per day/number of days per week times the total number of weeks being requested.

When requesting personal care services, indicate the number of hours per week times the total number of weeks being requested. The total hours requested on the PA/RF are required to match the total number of hours ordered by the physician. If requesting travel time, enter this as a separate item using procedure code W9902.

If sharing a case with another provider, enter "shared case with (name of other provider)" and include a statement that the total number of hours of all providers will not exceed the combined and total number of hours ordered on the PPOC.

When requesting two procedure codes to be used interchangeably (W9045/W9046), include a statement that the total number of hours will not exceed the combined total number of hours ordered on the PPOC.

When requesting permission to bill for multiple visits when only one visit is provided, enter "Authorization requested to bill for (number of) subsequent Home Health Aide visits due to (number of) continuous hours of care."

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ELEMENT 19 - QUANTITY OF SERVICE REQUESTED

Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure/item requested.

Disposable Medical Supplies (number of days supply)

Drugs (number of days supply)

Durable Medical Equipment (number of services)

Home Health (number of visits)

Home Health Therapy-PT, OT, Speech (number of visits)

Personal Care (number of hours)

Private Duty Nursing (number of hours)

Respiratory Care Services (number of hours)

For home health services based on visits, providers are required to figure the quantity of visits as follows:

1. Total each procedure code separately.
2. Count the actual number of days requested. (Use of the Julian Calendar is easiest: subtract the start date from the end date and add one more day.)

When one visit per day is requested, the actual number of days in the authorization period equals the total number of visits requested.

3. Divide the total number of days approved by 7 to determine the number of weeks. If the answer is not a whole number, round up to the next whole number.
4. Calculate, for each code, the total number of days per week.
5. Multiply the total of visits approved per procedure code by the number of days per week, then multiply this total by the number of weeks requested.

Example

1. A prior authorization request is submitted as follows:

Procedure code:

W9930 - 1v/day, 3 days/week

W9931 - 1v/day, 7 days/week

2. Total days requested:

Start Date 06/05/99

End Date 12/31/99

Total days requested = 200

3. Total weeks requested:

$200/7 = 28.6$, round up to 29 weeks

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4. Total services requested:

W9930 - 3 visits per week x 29 weeks = 87 visits

W9931 - 1 visit per day x 200 days = 200 visits

For private duty nursing, respiratory care, and personal care services based on hours, providers are required to figure the quantity of hours as follows:

1. Total each procedure code separately.
2. Count the actual number of days requested. (Use of the Julian Calendar is easiest: subtract the start date from the end date and add one more day.)
3. Divide the total number of days requested by seven to determine the number of weeks. If the answer is not a whole number, round up to the next whole number.
4. Calculate, for each code, the total number of days per week.
5. Multiply the total of hours approved per procedure code by the number of days per week, then multiply this total by the number of weeks requested.

Example

1. A prior authorization request is submitted as follows:

Procedure code:

W9900 (or W9903) - 14hrs./week

W9045 - 4hrs./day, 3 days/week

W9046 - 7hrs./day, 7 days/week

2. Total days requested:

Start Date 06/05/99

End Date 12/31/99

Total days requested = 200

3. Total weeks requested:

$200/7 = 28.6$, round up to 29 weeks

4. Total services requested:

W9900 (or W9903) - 14 hours per week x 29 weeks = 406 hours

W9045 - 4 hours per day, 3 days per week x 29 weeks = 348 hours

W9046 - 7 hours per day x 200 days = 1,400 hours

ELEMENT 20 - CHARGES

Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1", multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

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NOTE: The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to Terms of Provider Reimbursement issued by the Department of Health and Family Services.

ELEMENT 21 - TOTAL CHARGE

Enter the anticipated total charge for this request.

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT

"An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Reimbursement will be in accordance with Wisconsin Medicaid Program payment methodology and Policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

ELEMENT 23 - DATE

Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE

The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

In the blank space to the right of element 24, please indicate the start and end date for which services are being requested. If backdating is requested, specify backdating and indicate reason for need.